



<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b>		1. TRANSMITTAL NUMBER: 0 3 - 0 0 8	2. STATE GEORGIA
FOR: HEALTH CARE FINANCING ADMINISTRATION		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
		4. PROPOSED EFFECTIVE DATE April 1, 2003	
TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES			
5. TYPE OF PLAN MATERIAL (Check One):			
<input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION:  42 CFR 441.15		7. FEDERAL BUDGET IMPACT:	
		a. FFY                      2003                      \$ No Budget b. FFY                      2004                      \$     Impact	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 3.1- A, p. 3b		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 3.1-A, p. 3b	
10. SUBJECT OF AMENDMENT:  HOME HEALTH SERVICES ADJUSTMENT			
11. GOVERNOR'S REVIEW (Check One):			
<input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED:			
<input checked="" type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL: 		16. RETURN TO:	
13. TYPED NAME: MARK TRAIL		Department of Community Health Medical Assistance Plans 2 Peachtree Street, N.W. Atlanta, Georgia 30303-3159	
14. TITLE CHIEF, MEDICAL ASSISTANCE PLANS			
15. DATE SUBMITTED: June 24, 2003			
<b>FOR REGIONAL OFFICE USE ONLY</b>			
17. DATE RECEIVED: June 26, 2003		18. DATE APPROVED: November 6, 2003	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL: April 1, 2003		20. SIGNATURE OF REGIONAL OFFICIAL: 	
21. TYPED NAME: Susan Guerdon		22. TITLE: Acting Associate Regional Administrator Division of Medicaid & Children's Health	
23. REMARKS:			

7. HOME HEALTH SERVICES

Limitations

- a. Services are provided by Medicare certified home health agencies which have met all conditions of participation.
- b. Nursing visits (as defined in the State Nurse Practice Act) and visits rendered by home health aides who are working under the direction and supervision of a registered nurse, are provided up to 75 visits per recipient per calendar year. Accrued visits for physical, occupational or speech therapy are included in the 75 visits.
- c. Medical supplies, equipment and appliances suitable for use in the home are all covered items under home health.
- d. Physical, speech, and occupational therapy are provided.
- e. Patient admission to the Home Health Program shall be based on the Department's expectation that the care and services are medically reasonable and necessary for the treatment of an illness or injury as indicated by the physician's orders. Reimbursement for home health services shall be made according to departmental requirements and based on established criteria.
- f. Georgia Medicaid recipients that meet the requirement for a nursing facility level of care will receive the first 75 home health visits through the home health state plan benefit. The 76<sup>th</sup> visit will be covered under the skilled home health provisions of the waiver.

Non-Covered Services

Social Services (medical social consultation).

Chore services (Homemakers).

Meals on Wheels.

Audiology Services.

Visits in excess of 75 per recipient per calendar year. Visits in excess of 75 may be provided for EPSDT eligible recipients if medically necessary and prior approval is obtained.